2010 Military Health System Conference

Benefits of the Joint Incentive Fund (JIF)

Success Story: Wright-Patterson Stereotactic Radiosurgery

Sharing Knowledge: Achieving Breakthrough Performance

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27 January 2010

88th Medical Group
Wright-Patterson Air Force Base
United States Air Force

Introduction

- The Joint Incentive Fund (JIF)program—leveraging VA/DoD sharing opportunities
  - Section 721 of FY 2003 National Defense Authorization Act
  - Create innovative DoD/VA sharing initiatives
  - DoD and VA each contributed $15M per yr
  - JIF funded through FY07
    - Now extended through FY10

The WPAFB/Dayton VA JIF story

- Forces involved with WP JIF decision
  - Changing RVU accounting rules
    - "How do we stay economically viable?"
  - Maintenance of proficiency
  - Need to expand services
  - Modernization

A Changing RVU Paradigm

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON DC

MAR 23 2005

MEMORANDUM FOR ALL MAJCOM/SG

FROM: HQ USAF/SGO
110 Luke Ave, Room 400
Bolling AFB DC 20032-7050

SUBJECT: FY05 Standardized AF Workload Capture Guidelines

There has been a long-standing problem regarding the lack of understanding of how to account for workload and expenses in the AFMS. The primary issues that are causing the disconnect are: varied interpretations of the "visit" definition, varied interpretations of who qualifies as a healthcare provider, and lack of understanding of how our cost-accounting system (MEPRS) allocates expenses.

The attached matrix is designed to standardize workload capture, coding, and expense reporting across the AFMS. The focus is to mirror the civilian sector as closely as possible and ensure we are accurately capturing workload within parameters of existing DoD and Air Force policy. This policy is effective immediately.

As a note, "count" and "non-count" terminology is used by our information systems and is not meant as a reflection of the value of work being accomplished. Privileged and non-privileged providers are key to the success of the AFMS; data collection has a direct impact on your budgetary process.

A Changing RVU Paradigm

The attached matrix is designed to maximize accurate workload reporting and ensure the AFMS receives credit under the Perspective Payment System (PPS) for all of the work that is being performed in our facilities. The goal of this matrix is to bring together the business rules of MEPRS, Coding, and Uniform Business Office programs.

Further questions about this workload policy may be directed to MSgt JoAnn Milster at DSN 761-6504/joann.milster@pentagon.af.mil, or Major John Graves at DSN 761-6625/ john.graves@pentagon.af.mil.

Melissa A Rank

MELISSA A. RANK
Brigadier General, USAF, NC, SFN
Deputy Assistant Surgeon General, Health Care Operations
Office of the Surgeon General

Attachment:
FY05 DQ Standardization Matrix

A Changing RVU Paradigm

About RVU reports

Relative Value Unit (RVU) Coding Reports

Using RVU Coding Reports: The reports provide a profile of the RVU totals at the MTF and 3-level MEPRS clinic level. RVU totals are calculated by adding up the associated RVU values for each CPT and E&M code. Practice patterns are compared to AFMS and Peer Group performance. The "Delta" column of the report represents differences in MTF coding patterns. A delta is provided for comparing the MTF coding practices to overall AFMS coding patterns (all MTFS) and Peer Group coding patterns. Similarly, the MTF drill down to the 3-level MEPRS compares a particular clinic at the MTF with the same clinics (MEPRS) in the AFMS and Peer Group.

Update: Mar 1, 2005 - The Relative Value Units (RVUs) displayed on the BDQAS website were previously based on the 'Fully Implemented Facility Total' from the Centers for Medicare and Medicaid Services (CMS) workload RVU table which includes a facility component in addition to the provider workload generated value. M2 calculation of RVUs is based on 'Simple RVU' which only includes the provider workload generated values. **Effective 1 Mar 2005, all reports will use the Simple RVU value.**

The most sensitive level of analysis is comparison of MTF to Peer Group coding patterns since the population case mix is likely to be similar among MTFs in the same Peer Group. MTF coding improvements are based on determining if the significant differences are driven by unique

A Changing RVU Paradigm

	Full Facility RVUs	Simple RVUs
EKG	0.71	0.17
PFT	2.95	0
Frozen section	2.37	1.19
MRI Brain	13.86	1.48
Barium Enema	2.76	0.69
Radiation Pt Management	14.64	2.09
RT treatment planning	2.46	0
One Radiation Treatment	18.2	0
3D RT simulation	35.74	4.56

A Changing RVU Paradigm

	Full Facility RVUs	Simple RVUs
3D RT simulation	35.74	4.56
RT treatment planning	2.46	0
Radiation Pt Management	14.64	2.09
35 Radiation Treatments	637	0
Net RVU Difference	***690***	***6.65***

The March 2005 BDQAS update now costs us
683 RVUs per patient
($47,834 at $70 per RVU)!

The WPAFB/Dayton VA JlF story

- Partnering for proficiency
  - VAMC
    - 1 MD
    - 20-30 patients per day
  - WP
    - 2 MDs
    - 10-15 patients per day

The WPAFB/Dayton VA JlF story

- Expanding services/modernization
  (what we included in our package)
  - – High dose rate brachytherapy
    - GYN
    - Endobronchial
    - Esophageal
    - Skin
  - – Intracranial stereotactic radiosurgery
  - – Prostate seed brachytherapy

The “Perfect” JIF Proposal

- Choosing a project (JIF selection parameters)
  - Improves Quality of Care (20)
  - Improves Access to Care (20)
  - Mission Priority/Corporate Direction (10)
  - Return on Investment (10)
  - Measurable Performance Data Identified (10)
  - Supports VA/DoD Joint Strategic Plan (10)
  - Size and Scope of Impact (10)
  - Other Intangible Benefits (10)

The WP/VA JIF Proposal

- Why radiosurgery?
  - Inoperable brain tumors
  - Consolidation after whole brain RT
  - Benign conditions
  - Improved set up for “standard RT” (marginal benefit)
  - Adaptive vs. dedicated radiosurgery

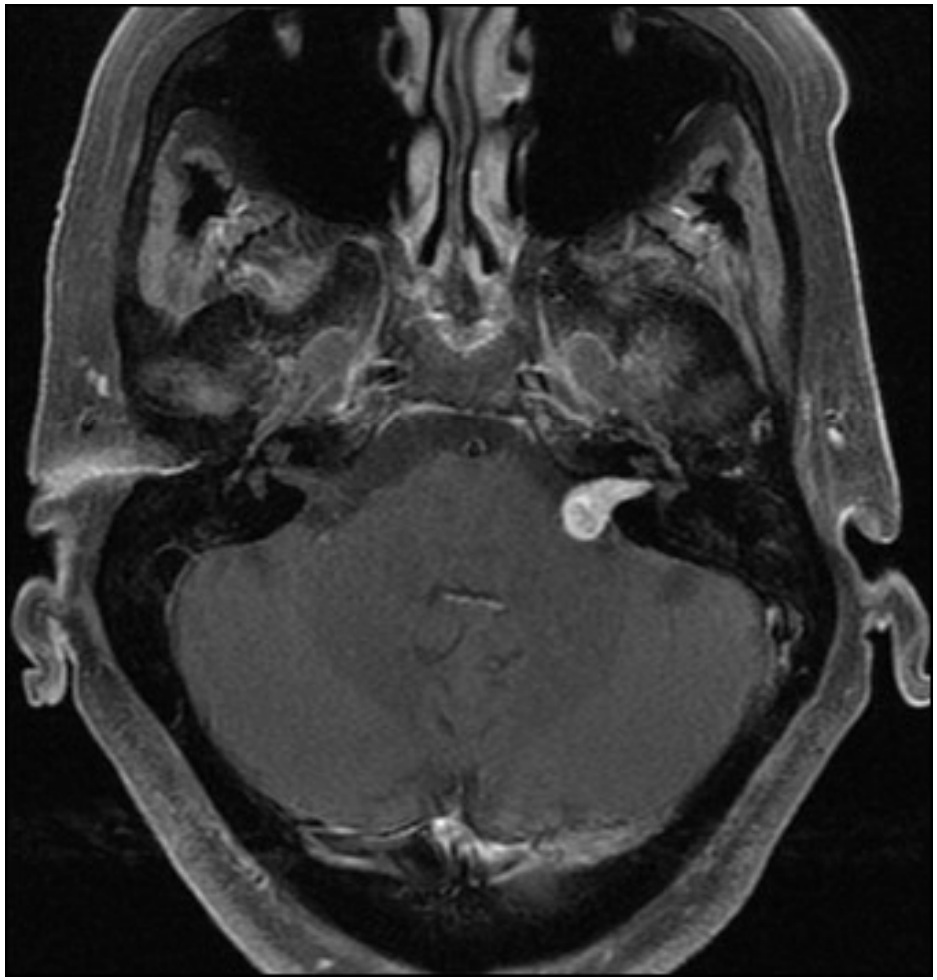
The WP/VA JIF Proposal

- Why HDR?
  - Leverages treatment vault
  - Wide menu of available applicators
    - Mammosite
    - GYN (cervix, uterine)
    - Skin
  - Relatively inexpensive to operate/maintain

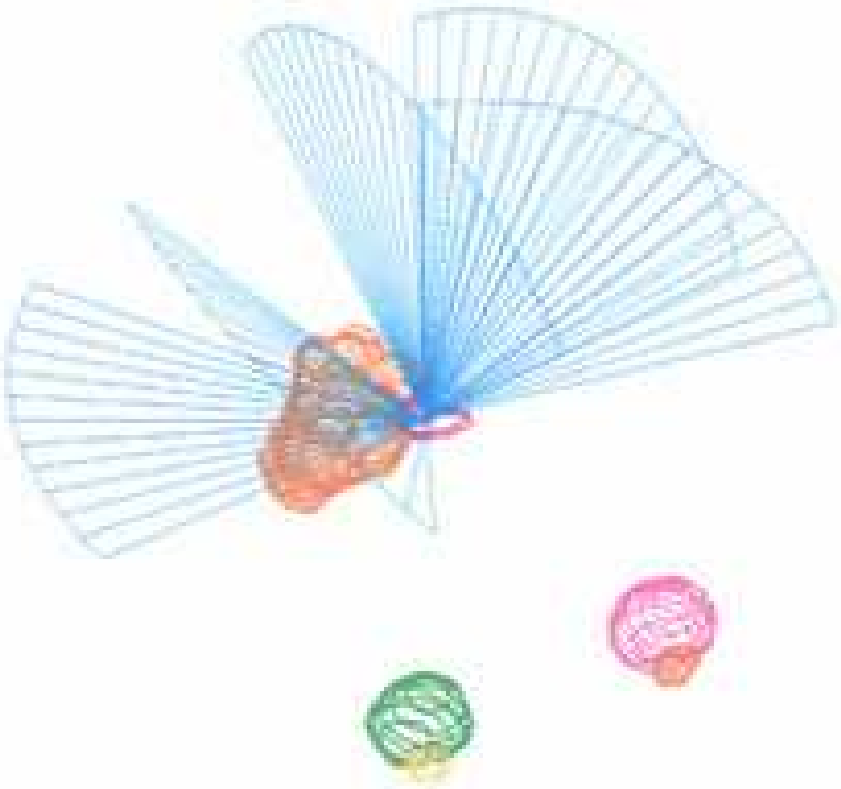
The WP/VA JIF Proposal

- Why prostate seeds?
  - Ultimate dose escalation
  - No randomized trial data comparing prostatectomy with RT or seeds
  - Quick treatment compatible with military demands (no daily RT treatments)
  - Leverages limited supply of urologists (particularly at VA)

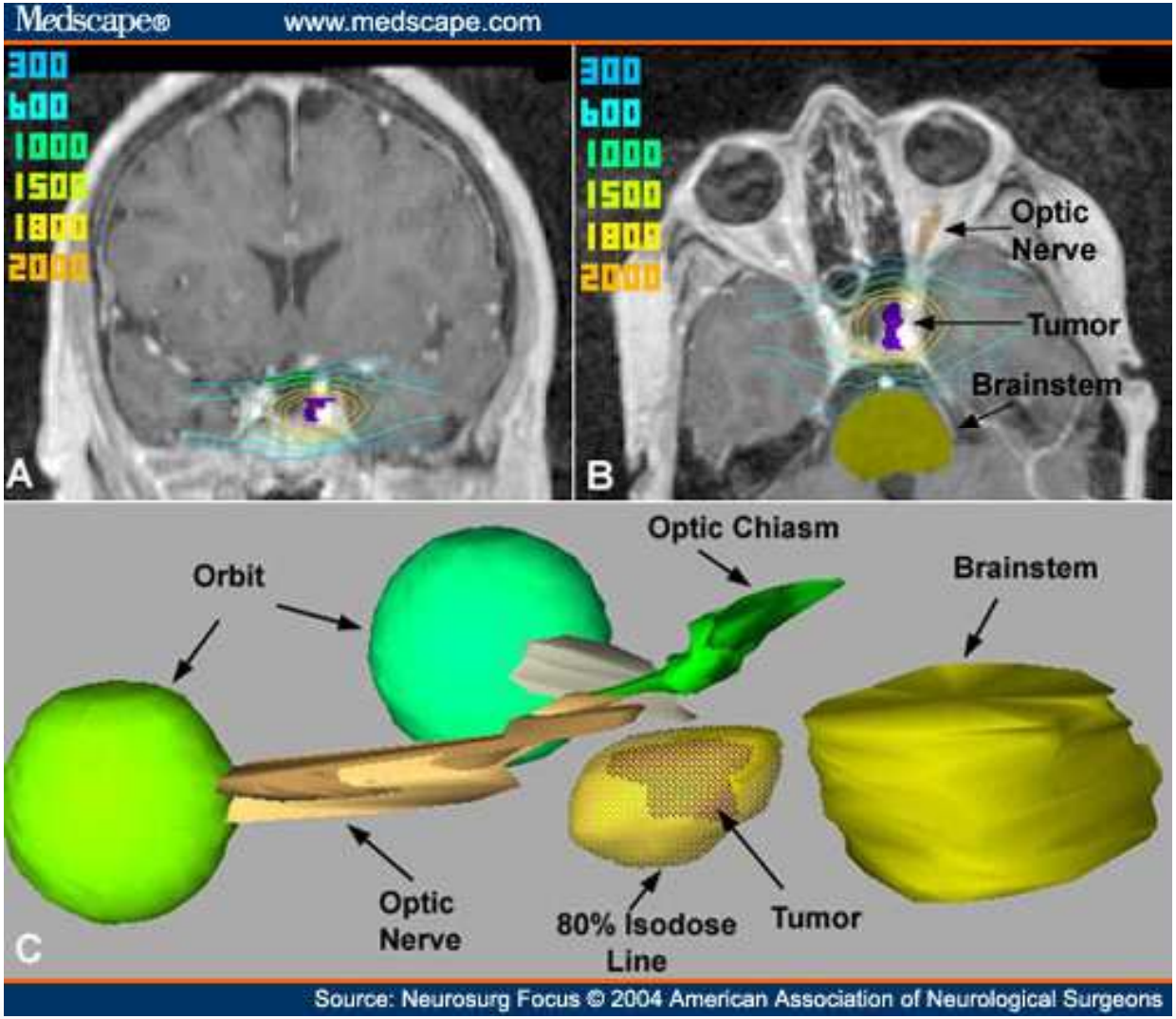
Stereotactic Radiosurgery (SRS)



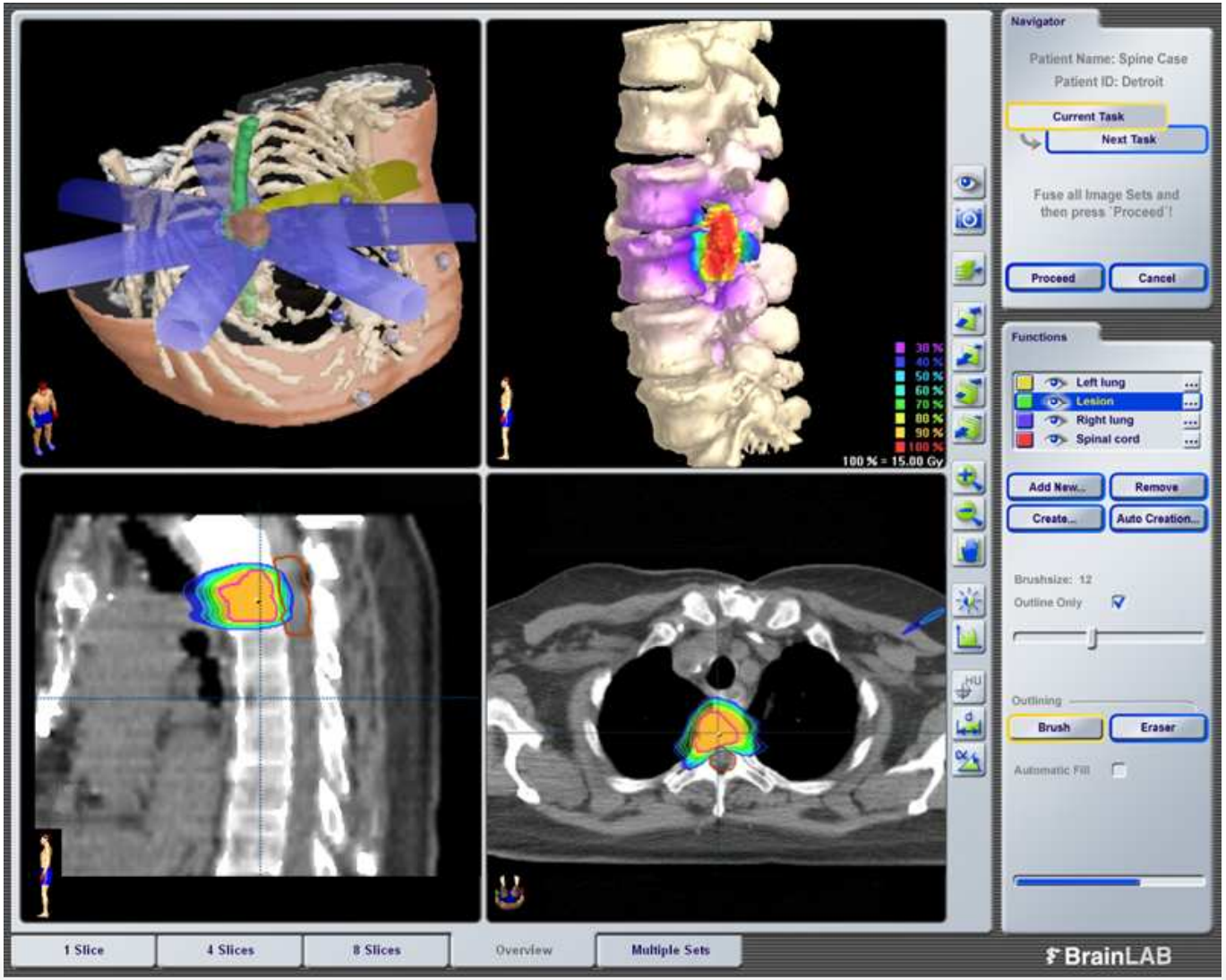
SRS: Conceptually



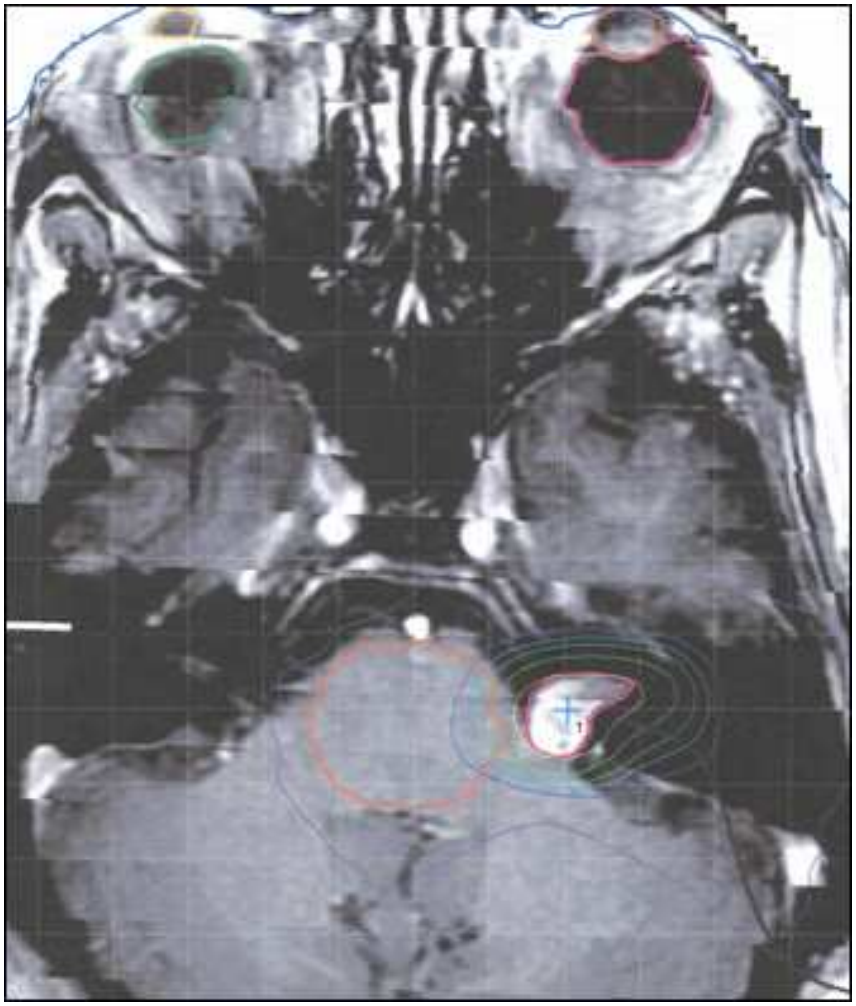
SRS: Treatment Planning



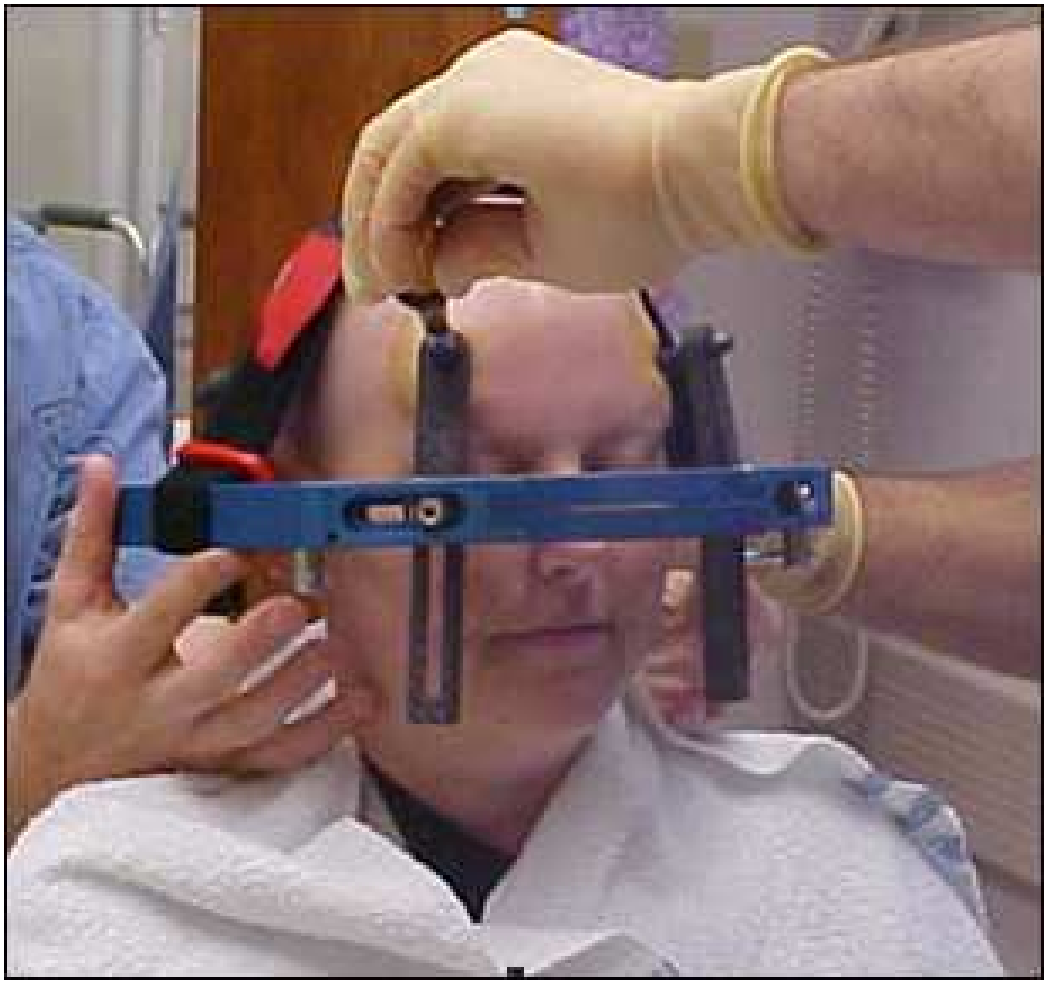
SRS: Our Specific Application



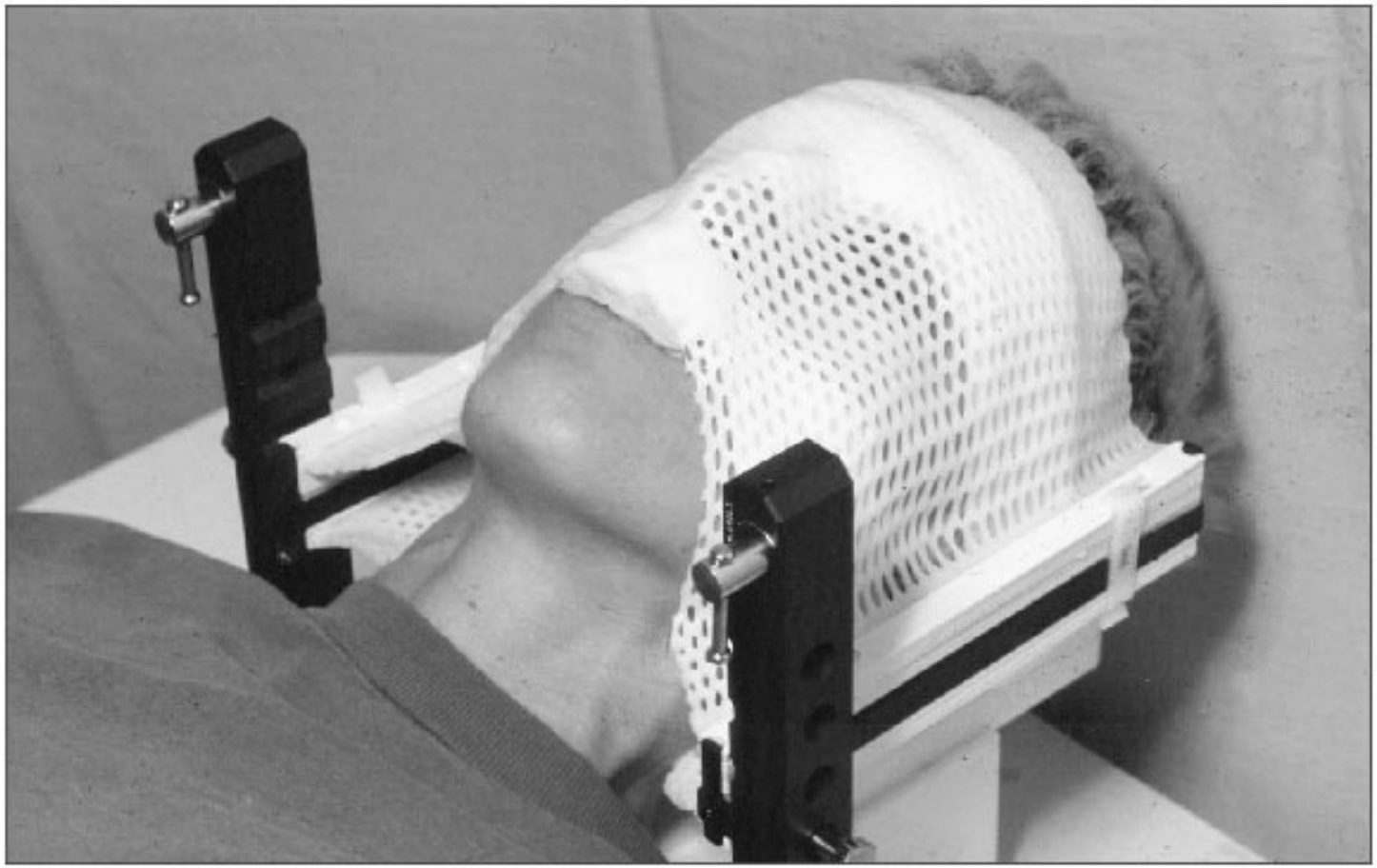
SRS: Dosimetry



SRS: Fixed Head Frame



SRS: Mask for Daily SRT (therapy)



SRS: Patient on Machine

SRS: Patient Treatment

The WP/Dayton VA Proposal

Radiosurgery equipment	$360,000
Mammosite equipment	$30,000
HDR Machine	$272,000
Radiosurgery Training	$10,000
24 VA prostate seed orders	$132,000
1 DoD Urology nurse	$120,000
1 DoD Urology tech	$50,000
Radiosurgery support contract	$72,000
HDR service contract	$59,000

Our Deployment Plan

- Assemble a team
  - Assigned a POC for each deliverable
- Used good project management skills
- Renegotiated all contracts
- Phased roll out
- Created “Cancer Care Coordinator” position
- Created a true multidisciplinary cancer center
- Collaborate

Lessons Learned

- Allow for the unexpected
- Be generous with salary estimates
- Pricing new service offerings is difficult
- Don’t include donated equipment
- Plan for sustainment
- Collaboration with referring staff is essential
  - VA prostate referral patterns
- ROI measured in years, not months

Summary

- WP/Dayton VA Radiation Oncology JIF provided astounding modernization and service expansion to DoD and VA patient populations
- JIF-like programs provide a clear and bright future path for sustainability of VA and DoD health care systems (a new paradigm)